MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01126 8

Reg. Dist. No. 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Howard
City or town: Elkridge (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Howard
City or town: Elkridge (If outside city or town limits, write RURAL and give nearest town)
Street No.: 5420 Race Rd. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ELMER LEON BROOKS

3.(b) Social Security Number: 219-01-2587

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Married

6.(b) Name of husband or wife: Jeannette
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6/30/1910

8. AGE: Years	Months	Days	If less than one day
36	9	22	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Labor
11. Industry or business: Calvert Distillery
FATHER 12. Name: Orgon Brooks
13. Birthplace: Balto. Md.
MOTHER 14. Maiden name: Mary Martin
15. Birthplace: Balto. Md.
16. Informant: Jeannette Brooks (Wife)
Address: 5420 Race Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/24/47 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: A.A.County, Md.
18. Funeral director: Charles G. Cooper
Address: 510-12 N.Carrollton Ave
19. April 24 19 47 (Date rec'd by registrar) A. W. Bedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/21/47 19 ..., at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to April 21 1947 and that I last saw him alive on April 21 1947

Immediate cause of death	DURATION
Leukemia	6 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thos. J. Woolridge M. D. or other
Address: Elkridge Md. Date signed: 4-23-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

01127

CERTIFICATE OF DEATH

Reg. Dist. No. 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Howard

City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 59 yrs 6

Hospital, institution, or street address where death occurred: Main Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Marcellus Hammond

3. (b) Social Security Number: 217-01-3299

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Achsah Hammond

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 18, 1887

8. AGE:

Years	Months	Days	If less than one day
59	5	19	____ hrs. ____ min.

9. Birthplace: Howard Co., Md.
(Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business:

FATHER
12. Name: John Russell
13. Birthplace: Howard Co. Md.

MOTHER
14. Maiden name: Lottie Hammond
15. Birthplace: Maryland

16. Informant: Alice Green

Address: Ellicott City Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 9 1947 (month) (day) (year)

Cemetery or crematory: Fuller Family Cem.

Location: Pine Orchard, Md.

18. Funeral director: Easton Sons

Address: Ellicott City, Md.

19. April 8, 1947 (Date rec'd by registrar) John B. Leughman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6, 1947, at 7:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-5, 1947, to 4-7, 1947 and that I last saw h. living alive on 4-6, 1947

Immediate cause of death: Acute Pulmonary Edema — 2 days
Arteriosclerotic Cardio-Vascular Disease — 1 year

Due to: ____

Due to: ____

Other conditions: none

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op. ____

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: George E. Benston M.D. (M. D. or other)

Address: Ellicott City, Md. Date signed: 4-8-47

01128

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Diat. No. 194

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Howard
City or town: Dayton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Dayton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: JOYCE EMILY KOSH

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	COL	SINGLE

6.(b) Name of husband or wife: -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 25, 1947

8. AGE:

Years	Months	Days	If less than one day
		5	..... hrs. ..... min.

9. Birthplace: Dayton, Howard Co., Md.
(Town, county, and state)

10. Usual occupation: infant

11. Industry or business

FATHER
12. Name: Leo Howard Kosh
13. Birthplace: Howard Co., Md.

MOTHER
14. Maiden name: Helen Carroll
15. Birthplace: Howard Co., Md.

16. Informant: Leo Howard
Address: Dayton, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 4-30-47 (month) (day) (year)
Cemetery or crematory: at home
Location: Dayton, Md.

18. Funeral director: Leo Howard Kosh
Address: Dayton, Md.

19. 4-30 1947 (Date rec'd by registrar) Marie C. Whitaker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1947, at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25 1947 to April 29 1947 and that I last saw her alive on April 29, 1947

Immediate cause of death	DURATION
Immaturity (twin)	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Charles S. Whitaker M.D.
M. D. or other
Address: Clarksville, Md. Date signed 4/30/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01129

CERTIFICATE OF DEATH

Reg. Dist. No. 8C

M

1. PLACE OF DEATH:
County HOWARD
City or town ELLICOTT CITY - RURAL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 DAYS
Hospital, Institution, or street address where death occurred:
PINEL CLINIC - ELLICOTT CITY MD.
How long in hospital or institution? 11 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County BALTIMORE CITY
City or town BALTIMORE 15 MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5807 CLOVER RD
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME ANNA PASS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife HARRY
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) MONTH + DAY UNKNOWN 1882

8. AGE: Years	Months	Days	If less than one day
65	?	?	____ hrs. ____ min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace RUSSIA

MOTHER
14. Maiden name NOT KNOWN
15. Birthplace RUSSIA

16. Informant MRS. S. FRIEDMAN
Address 5807 CLOVER RD. BALTO. MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 4-3-47 (month) (day) (year)
Cemetery or crematory ROSEDALE
Location Phil Rd + Hamilton Ave
18. Funeral director Jack Lewis Inc.
Address 1432 E. Baltimore St.
19. April 2 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 2nd 19 47, at 7 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 23rd 19 47, to APRIL 2nd 19 47 and that I last saw h.e.a. alive on APRIL 2nd 19 47

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	25 HOURS
Due to GENERALIZED ARTERIOSCLEROSIS	3 YEARS
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____
Autopsy results ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE Helmut Prager M.D.
M. D. or other
Address Ellicott City, Md. Date signed 4/2/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

01130 D

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77c

CERTIFICATE OF DEATH

Reg. Diat. No.....

1. PLACE OF DEATH:
County..... Howard
City or town..... Waterloo
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, Institution, or street address where death occurred:
Washington Boulevard
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County —
City or town Baltimore city
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4800 Curtis Ave
(If rural, give LOCATION)
2.(a) If veteran, name war World War I ✓

3. (a) FULL NAME Charles A. Schaffer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Pauline Schaffer
6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) May 3, 1890

8. AGE: Years 56 Months Days If less than one day ....hrs. ....min.

9. Birthplace Blacksburg Va (Town, county, and State)

10. Usual occupation Tavern Operator

11. Industry or business Retail Liquor

FATHER 12. Name James Schaeffer
13. Birthplace Va

MOTHER 14. Maiden name Madey Martin
15. Birthplace Va

16. Informant Mrs Pauline Schaeffer
Address 4800 Curtis Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/30/47 (month) (day) (year)

Cemetery or crematory Arlington Cem

Location Arlington, Va

18. Funeral director John F Kenney Sons

Address 715 Light St

19. April 29 1947 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1947 at 2.40 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 27 1947, to April 27 1947
and that I last saw him alive on at no time 19.....

Immediate cause of death	DURATION
Acute Alcoholism	1 day.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury Injured at work?

23. SIGNATURE Alpha N Herbert M.D.
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other
Address Ellicott City Md Date signed 4-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Mrs. L. H. [illegible]

103 W. [illegible] St.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01131 8

82

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:
County Howard
City or town Alpha
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
Old Frederick Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Howard
City or town Alpha
(If outside city or town limits, write RURAL and give nearest town)
Street No. Old Frederick Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war World War 1

3.(a) FULL NAME
Cora Tribull

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1886.

8. AGE: Years	Months	Days	If less than one day
60	8	21	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Reinhold F. Tribull
13. Birthplace Germany

MOTHER
14. Maiden name Elizabeth Richstein
15. Birthplace Pa.

16. Informant Miss Adeline Tribull
Address Old Frederick Rd. Howard Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1/47. (month) (day) (year)
Cemetery or crematory Baltimore National
Location 5501 Frederick Rd. Baltimore, Md.

18. Funeral director Harry A. Witzke
Address 4101 Edmondson Ave.

19. April 30 19 47 (Date rec'd by registrar) A. M. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28/47. 19 , at 6:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 19 23 to 4/28 19 47
and that I last saw h alive on 4/28 19 47

Immediate cause of death Transverse Myelitis of cord — DURATION 25 yrs

Due to

Due to

Other conditions Bulbar paralysis — 2 days

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. F. Adgie M. D. or other
Address 332 Fulton Ave Date signed 4/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-6

CERTIFICATE OF DEATH

01132

Reg. Dist. No. 190

M

1. PLACE OF DEATH:

County Howard

City or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3-8

Hospital, Institution, or street address where death occurred:
Rokeby

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Howard

City or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rokeby
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Parker Worthington

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife George Worthington

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 29 1863

8. AGE:

Years	Months	Days	If less than one day
83	5	14	..... hrs. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER
12. Name Addison R. Foard
13. Birthplace Baltimore Md

MOTHER
14. Maiden name Mary Parker Jones
15. Birthplace Baltimore Md

16. Informant Mrs Mary Morris Bright
Address Elkridge 27 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 12 1947 (month) (day) (year)

Cemetery or ~~Crematory~~ Grace Cemetery

Location Elk Ridge Md

18. Funeral director Henry H. Jenkins Sons Co.

Address McCulloh & Richard Sts

19. April 11 1947 (Date rec'd by registrar) (Miss) E. Bird Wilhelm Registrar
Local

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 11 1947, at 7 45 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 13 1947, to Apr 11 1947

and that I last saw her alive on Apr 10 1947

Immediate cause of death	DURATION
Carcinoma of Stomach	6 mos.
Due to General Carcinomatosis	3 mos.
Due to Myocardial Degeneration	1 mos.
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. B. Bernard Jr. M. D. or other

Address Elkridge Md Date signed 4/14/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

MARGIN RESERVED FOR BINDING